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"Brought Me Back to Life": An Evaluation of the North Cumbria Maternal Mental Health Service

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Birth trauma and pregnancy-related distress are common issues for women and birthing people. The North Cumbria Maternal Mental Health Service (MMHS) was established in March 2022 in direct response to the NHS (NHS, 2019a), which called for the implementation of regional maternal mental health services and support networks. This paper evaluates the performance and effectiveness of the North Cumbria MMHS during the 2023–2024 financial year, taking into account local and national challenges and their clinical implications. Patient outcome data, collected using the Clinical Outcomes in Routine Evaluation 10 and the Warwick–Edinburgh Mental Well-being Scale, were analyzed to assess service effectiveness across 2023–2024. A thematic analysis was conducted of all qualitative patient feedback. A Wilcoxon signed–rank test showed a significant reduction in psychological distress and a significant increase in mental well-being post-intervention (p = .005). Most participant feedback was positive, and thematic analysis yielded five key themes: the importance of the therapeutic relationship, gratitude, the return to self, tools for moving forward, and areas for improvement. In conclusion, notable improvements in post-treatment outcomes were observed, and patient feedback was overwhelmingly positive. The data indicate that, despite

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significant challenges, the North Cumbria MMHS provides a vital and effective service to women and birthing people, offering unique insight into regional MMHS operations.

Keywords: maternal mental health, maternity, maternal, NHS, perinatal mental health, birth trauma, perinatal loss, Ockenden

Birth trauma and pregnancy-related distress are increasingly common issues experienced by women and birthing people across the United Kingdom (UK). Findings show that as many as 4-5% of individuals go on to develop clinically relevant post-traumatic stress disorder (PTSD) following childbirth, equating to between 25,000 and 30,000 women each year (The All-Party Parliamentary Group on Birth Trauma [APPGBT], 2024). Importantly, high rates of comorbidity have been observed between PTSD and postpartum depression, which can have a severe impact on women and their families, potentially impairing maternal-infant bonding and indirectly affecting infant health (Dekel et al., 2017; Williams et al., 2016). These issues also impose a substantial economic burden on society, estimated at £8.1 billion annually for each birth cohort in the UK (Bauer et al., 2014). This, therefore, represents a large population that may require some form of specialist psychological treatment.

In 2018, NHS England and NHS Improvement (NHSEI) ran consultation events with a range of perinatal and maternal health partners and stakeholders, ahead of the NHS Long Term Plan's publication. A significant finding was that some women with moderate-severe or complex psychological needs linked with their maternity experience were falling through the gaps in existing service provision and failed to meet the criteria for community perinatal mental health services. It was posited that these women needed specialist psychological support beyond that provided by Improving Access to Psychological Treatment (IAPT), counseling, and bereavement services. Thus, the development and implementation of regional Maternal Mental Health Services (MMHSs) were proposed in two major policy documents to address this unmet need (NHS, 2019a; NHS, 2019b).

However, national concerns about the standard of maternity care are longstanding and have been brought into sharp focus in recent years. For example, the seminal findings of the final Ockenden report (Department of Health and Social Care, 2022) highlighted numerous areas for improvement to

maternity services across England, including the integration of regional MMHSs and access to "timely emotional and psychological support without the need for formal mental health diagnosis" (p. 175). Notably, this was to be accessible to mothers, partners, and families and be delivered by psychological practitioners with specialist expertise and training in maternity care. Further, the report stated that all trusts should ensure that midwives responsible for coordinating a labor ward setting attend training to aid in advanced decision-making, with consideration for psychological health playing a key role.

Most recently, the APPGBT (2024, p. 45) heard evidence that the provision of maternity services is "very much a postcode lottery", with many having been unsuccessful in accessing mental health support due to a failure to recognize PTSD symptoms, services refusal to accept women who were not ill enough or, in some cases, too ill, and exceedingly long wait lists with no interim support available. In other cases, it was reported that women who did receive therapeutic input were often treated by psychological practitioners with no experience of working with birth trauma, leading to an immediate increase in distress. As such, despite repeated calls for the provision of specialist mental health support, the level of care for this population appears to remain largely unsatisfactory and inequitable.

Nevertheless, despite the introduction of maternal mental health teams across all NHS England localities, these services face specific challenges that can act as barriers to treatment (NHS, 2019a). For example, the APPGBT (2024) stated that 73% of these teams reported underfunding in the 2022-23 financial year and that they experienced significant difficulties securing continuous funding to ensure future service provision. Consequently, this has brought about major staffing challenges, exacerbated by the somewhat rapid creation and implementation of these services across the country. These issues can directly affect patient care, a pressing example being funding issues that result in trouble recruiting and retaining full-time staff, contributing to burnout among existing team members and increased wait times for service users during a period of life where they are uniquely vulnerable. As such, it is clear that the impact of financial decisions made at an organizational level is of key consequence to the delivery of MMHSs, available resources, and the quality of care the service is or feels able to provide.

As mentioned, a key step taken to address concerns in maternity care is the establishment of regional MMHSs, tasked with providing treatment and support for mental health difficulties arising from pregnancy and childbirth

(APPGBT, 2024). In direct response to these recommendations, the North Cumbria Maternal Mental Health Service (MMHS) was launched in March 2022. The service integrates psychology into maternity and gynecology, delivering evidence-based psychological assessments and therapy to women and birthing people with emotional difficulties that relate to, or arise from, pregnancy and childbirth. This includes birth trauma, loss, and fears and phobias impacting maternity care. The North Cumbria MMHS also aims to contribute to the supervision and training of maternity staff in psychological skills and trauma-informed care. The service sits within the Physical Health and Rehabilitation Psychology (PHRP) service and is funded for 1.4 whole-time equivalent (WTE) staff members. However, during 2023-2024, several staff configuration changes occurred at the MMHS due to maternity leave. In this case, appropriately qualified cover was achieved through external recruitment and transfer of staff from other PHRP pathways. As such, professionals working in the MMHS included Senior Clinical Psychologists, Senior Counseling Psychologists, and Cognitive Behavioural Therapy (CBT) Therapists.

This article examines data collected by the MMHS team in North Cumbria during the 2023-2024 financial year and considers patient outcomes and anecdotal experiences. It is our view that the North Cumbria MMHS provides a good case study for demonstrating the practical challenges of daily maternal mental health care whilst still delivering a high level of patient care. We will discuss how we have dealt with challenges encountered thus far, the perceived impact of these difficulties on patient outcomes, and consider how the North Cumbria MMHS may provide examples and learning opportunities for other maternity services, alongside further improvements to our own practice.

Methods

The data was collected over the 2023-24 financial year. The geographical region covered was North Cumbria (Figure 1). In this area, there are three NHS birthing venues: Cumberland Infirmary, West Cumberland Hospital, and Penrith Birthing Centre. According to as-yet-unpublished data from Family Services at North Cumbria Integrated Care, a total of 2,516 babies were born to 2,483 women across these sites during this period.

Figure 1

Map of North Cumbria (Shown in Green)

Note. Reprinted from Primary Care Services North Cumbria. (2017). Where is North Cumbria? https://www.primarycarenorthcumbria.co.uk/about-us/place

The North Cumbria MMHS received 156 referrals overall, of which 139 were accepted, and 93 were assessed and treated. The average age of service users referred was 30.71 years. The majority of those referred identified as White British. Of the initial 156 referrals received, 56% of individuals had previously accessed some form of mental health service, with IAPT being the

primary source of prior support. Approximately 52.48% of those referred were based in Carlisle, 21.28% were referred from Allerdale, and 14.89% and 11.35% were referred from Eden and Copeland, respectively.

Service users can be referred by any member of their maternity care team or another healthcare professional. Referral sources consisted mainly of midwives, perinatal mental health midwives, and GPs. A full breakdown of referral reasons is shown in Table 1. It is noted that 17 referrals lacked a clear reason, including some that were missing and others that were unclear or vague.

Table 1

Reason for Referral into MMHS (n = 156)

Referral reason	Count
Anxiety about pregnancy and childbirth	10
Birth trauma	69
Fear of childbirth	11
Fear of hospital environment	1
Medical termination of pregnancy	4
Miscarriage	21
Multiple IVF attempts or assisted pregnancy	2
Neonatal death	6
Stillbirth	1
Foetal abnormalities	2
Other	12
No clear reason	17

Intervention and Outcome Data

Several treatment modalities were offered to service users, including one-to-one Cognitive Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), and Compassion Focused Therapy (CFT), with some service users being offered more focused support around birth planning and preparation. Indirect work was also carried out where appropriate, mainly via group case discussions, care coordination, and MDT working. Assessment and treatment were carried out via several different mediums, including face-to-face, video conferencing, and telephone. Overall, the service had an average

referral-to-assessment time of 43 days and an average assessment-to-treatment time of 33 days.

Outcome data were collected both pre- and postintervention using two measures validated for routine use: the Clinical Outcomes in Routine Evaluation-Ten-Item Version (CORE-10; Barkham et al., 2013) was used as a measure of psychological distress, with scoring categories shown in Table 2. The Warwick–Edinburgh Mental Well-being Scale (WEMWBS; Tennant et al., 2007) was used as a measure of general mental well-being. Service users were also invited to complete a service feedback measure, developed internally by the MMHS team, once their work with the service had ended. This measure comprised both qualitative and quantitative items, with the latter optional. For this evaluation, both outcome data and service feedback from the 2023–24 financial year were analyzed.

Table 2

CORE-10 Scoring Categories

Score	Descriptor
0-5	Healthy
6-10	Low Level
11-14	Mild
15-19	Moderate
20-24	Moderate-to-Severe
25+	Severe

Regarding the qualitative data, a thematic analysis was conducted by one of the authors (CM) to identify recurrent themes regarding how individuals experienced the MMHS and what was most important to them. This process followed that outlined by Braun, Clarke, Hayfield, and Terry (2019), consisting of 6 reflexive phases: Familiarisation with raw data, inductive generation of codes, construction of themes, revision of themes, defining themes, and producing the final report. This data was collected via anonymous surveys sent to clients following the conclusion of their treatment with the team, which asked them to rate and describe their experience.

Results

In total, 12 completed sets of pre- and postintervention outcome measures were collected, with results indicating largely positive change (Table 2).

Table 3

Median Outcome Measures Scores Pre-Intervention and Post-Intervention (n = 12)

Outcome measure	Pre-intervention median score	Post-intervention median score	Median Difference Estimate	Effect Size (95% confidence interval)
CORE-10	14.00	4.50	7	-1.24 (-2.17- -0.37)
WEMWBS	40.00	55.00	-12.5	1.58 (0.67- 2.5)

To determine whether there was a statistically significant difference between pre-intervention and post-intervention outcome scores, a Wilcoxon signed–rank test was performed, which indicated a statistically significant decrease in CORE-10 scores post-intervention (Table 3), with a large effect size. With median scores falling from 14 to 4.50, as higher scores suggest greater distress or symptom severity, these results show a significant decrease from moderate-severe psychological distress to low levels. Here, only one negative rank was observed compared with nine positive ranks, suggesting that the majority of service users recognized a decrease in psychological distress post-intervention. For two cases, no difference in scores was seen, with psychological distress remaining at low and moderate levels.

Likewise, as shown in Table 3, a significant increase in WEMWBS scores was observed post-intervention, with a median increase of 40-55. The effect size was again large. Higher WEMWBS scores indicate greater positive mental well-being, with the results suggesting improvement post-intervention. In this case, no negative or tie ranks were observed, and all service users reported post-intervention increases in positive mental well-being.

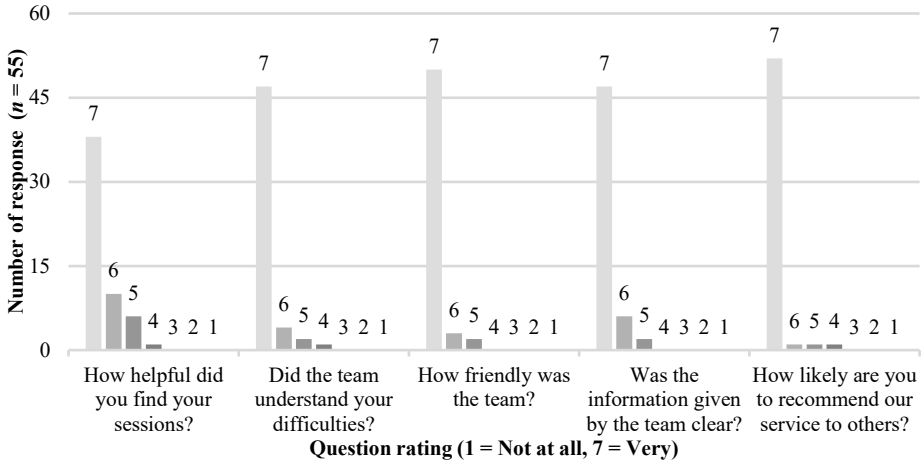
Quantitative Service Feedback

As previously stated, 55 service users provided quantitative service feedback at various points in their journey through the North Cumbria MMHS (including during and after the intervention). Scores for quantitative items

ranged from 1-7, whereby 1 indicated “Not at all” and 7 indicated “Very”. Feedback was largely positive, with the majority of respondents answering 7 to each question (Figure 2), suggesting that the service is providing a valuable resource. Service users consistently reported that their sessions were helpful, the team was friendly, and their clinician understood the difficulties they were experiencing.

Figure 2

Quantitative MMHS Patient Feedback (n = 55)



Further, service users were asked to share what they felt the North Cumbria MMHS currently did or delivered well, with key responses including helping patients understand their difficulties, giving them hope, and empowering them to make decisions about their care (see Table 3). For those who selected “other”, service users reported that the MMHS had “made [them] feel heard and understood,” “helped [them] feel [their] power and worth again” and “brought [them] back to life.” For a complete list of “other” responses, see Appendix.

Qualitative Patient Feedback

In total, 41 service users provided qualitative feedback for the MMHS about what they felt the service did well and any other comments or feedback on their experience. Thematic analysis of these responses revealed five

prevalent themes: The importance of the therapeutic relationship, gratitude, the return to self, tools to manage moving forward, and areas for improvement.

The Importance of the Therapeutic Relationship

The first theme identified was the importance of the therapeutic relationship, specifically how individuals were made to feel by practitioners and how they perceived staff's attitudes towards them and their difficulties. Overall, MMHS staff were regarded as "incredibly kind and supportive" and helped individuals to "feel understood, respected and safe." The majority of comments received centered on the "amazing work by caring and compassionate health workers" who were "exceptionally approachable and made [them] feel very comfortable." In particular, service users reported the service helped to validate their experiences and "feel that [their] worries and fears weren't irrelevant or unjustified; that they weren't just silly things."

Other key elements included service users feeling able to "talk freely about [their] experiences in a safe space," being "given the time…to process events that had happened" and being "guided by exactly the right person who understood maternal struggles and [their] complexity." Service users felt that "communication was good and appointments were made to suit [their] needs and availability," which helped them access appropriate support. One service user remarked, "Very friendly member of staff working with myself who I felt comfortable talking to and sharing my worries and fears." With another expressing a similar sentiment, "This service was fantastic. [Practitioner] was brilliant. I felt like I had someone to go to." The supportive attitudes of clinicians were highlighted by another who stated, "The support provided by the service has been invaluable. [Practitioner] has shown kindness, patience, and understanding at a time when I have felt my lowest."

Gratitude

The second theme identified was the gratitude individuals expressed for the support offered by the MMHS and how it has "truly been a lifeline at a time of need." Service users spoke of being "eternally grateful" for a service they viewed as "essential" and credited the approach of "getting to the root of the issue" as vital to their journey. Further, it was commonly noted that individuals "don't know where [they] would be right now" without the service's input and felt it "got [them] to a place [where they] felt [they] could cope." Importantly,

the feedback highlighted that individuals "couldn't have asked for a better experience" and would "highly recommend the service" to others in a similar position.

> I cannot thank this service enough at a time when a lot of avenues plus services post-natally had not managed to stop a downwards spiral; she not only stopped it but helped me to climb out of the hole with many new skills. Motherhood is a hard journey made a lot easier with the support and guidance of this service. (P47)

The vital role of the interventions offered by the MMHS was also remarked on, "I cannot thank my psychotherapist enough. The EMDR therapy I received has been paramount in my recovery, and I am so grateful this service is available."

The Return to Self

The third theme identified was the return to self, underscoring the transformative effects of the work completed in allowing individuals to reclaim their lives and feel more in control. Several service users detailed how their experience "had been truly life changing" and had "brought [them] back to life. [Giving] my husband his wife back and my babies their mummy back." This extended into individuals feeling like they were "now the person [they] wanted to be" and that the work had "helped [them] reclaim life and control" to "feel [their] power and worth again."

The role that the MMHS played in patients' recovery journey was described as one as "They scooped me up at my lowest and turned things around for me… After six months of hell, I'm finally back to me again and enjoying the last part of my maternity leave."

Another patient spoke of the role the MMHS played in allowing them to have a positive experience following the birth of their child. "It was truly life-changing, and I appreciated the support through my latest pregnancy. We finally welcomed our little daughter, and it is because of this service that I felt ready for this little wonder with an open heart" (P50).

Tools to Manage Moving Forward

The fourth theme identified relates to individuals learning particular tools and being given tangible resources to take away in order to help them move

forward. Specifically, individuals reported that they were given "good strategies to take away," focusing on emotional regulation, teaching them "how to cope with feelings [and] to prevent them from escalating in the future," and to "detangle [their] thoughts and feelings and get a better understanding." Service users also felt they were given a valuable "understanding [of] how the brain works," with one noting that their practitioner "explained how the brain is working and what is going on when [they] have flashbacks and PTSD symptoms." In addition, others reported that their sessions had "really helped [their] communication with loved ones," which had a positive impact on wider family dynamics and improved understanding of their experience in those around them.

> I am hopeful this will give me the skills going forwards to manage with life's difficulties without it taking hold of me as it has in the past. I hope that I will now not struggle in the same repetitive way. (P47)

One service user described the importance and effect of these strategies as helping them "tremendously to deal with previous trauma relating to pregnancy loss. I gained valuable understanding about my feelings and coping mechanism and we were able to develop strategies and move through grief."

Areas for Improvement

The final theme identified was areas for improvement. A total of four suggestions were made by service users, two of which related to the Birth Reflections service, which sits separately from the North Cumbria MMHS. The complaints in this instance related to long wait times and the wish for it to be integrated into the MMHS, with suggestions that "1 or 2 debrief style session[s] in the first few weeks" with Birth Reflections should precede any input from the MMHS.

> I also want to chase an appointment with a midwife to go through my notes, formerly known as the reflections service. It has been 8 months since I first requested this. I feel like the answers I need and the opportunity to speak to a midwife will help me through my trauma, along with therapy sessions. For me, they need to coincide. (P9)

> CBT has been brilliant, but I was first told I would receive a 2-step approach: CBT alongside my reflections, which I requested 16 months ago now. I am yet to hear from the reflections service despite chasing. I am

> really disappointed, as this is the last step in my healing, and I really need that closure to be able to move on. (P21)

This comment by P21 highlights the overall difficulties faced in maternal mental health care. While the service offered valuable input, wait times and experiences across the NHS can be further areas for improvement; raised was the need for more communication about appointment waiting times. Here, one patient reported that her practitioner "had to take time off work due to illness but then did not respond to [their] message after returning to work for 2 weeks." As such, this patient felt that they had "to chase to find out [their] next appointment" and "was left in limbo for 5 weeks and felt almost worse than before [they] started [their] therapy."

Lastly, two individuals suggested "open up to dads too," indicating a desire for the MMHS to expand its inclusion criteria to include fathers and partners who may have experienced difficulties throughout the maternity journey.

> I also think it would be beneficial to include partners/husbands in some way. In my experience, the trauma from the birth of our first child impacted my partner hugely too; therefore, if they could be incorporated, it would be brilliant. (P42)

Discussion

A Wilcoxon signed–rank test showed significant differences in outcome measure scores post-intervention with the North Cumbria MMHS. Specifically, a significant decrease was observed in scores on the CORE-10, indicating a reduction in psychological distress and symptom severity following MMHS input. In addition, a significant increase in WEMWBS scores was observed post-intervention, suggesting improved mental well-being. These results, alongside quantitative service user feedback speaking to sessions being regarded as helpful and clinicians as sensitive and understanding, support the clinical relevance of the North Cumbria MMHS in making meaningful change to the lives of service users. However, at this time, we are unable to provide any estimates of general cost savings attributable to this work, as healthcare usage proved difficult to accurately cost and calculate for this clinical population.

The service benefits are further demonstrated by the thematic analysis of qualitative feedback, which revealed key themes: the importance of the therapeutic relationship, gratitude, the return to self, tools to manage moving

forward, and areas for improvement. These insights provided valuable information on service users' views of the care they received from the North Cumbria MMHS. In summary, these findings highlighted that the quality of therapeutic relationships was foundational to all work undertaken and that this dynamic, rooted in kindness and compassion, allowed service users to feel understood, safe, and respected. The authors believe that this paved the way for positive appraisals of working with the MMHS, with service users reporting that the input received was essential to their recovery journey and enabled them to reclaim aspects of their lives and identity they believed had been lost. Service users also reported learning helpful tools and being given tangible resources, which aided their ability to emotionally regulate, communicate more effectively, and improve their understanding of their experience. Finally, four areas of improvement were suggested by service users: the desire to see the North Cumbria MMHS work more closely with the NCIC Birth Reflections service, better communication surrounding expected waiting times, and the expansion of our criteria to include fathers and partners.

A key recommendation from the final Ockenden report was timely access to psychological support, with personalised input for those with complex needs to be delivered by specialist practitioners experienced in maternal mental health care (Department of Health and Social Care, 2022). The authors argue that the North Cumbria MMHS meets both identified needs, as evidenced by positive patient feedback. Despite the majority of referrals being related to birth trauma, the service has helped women who have experienced a variety of birth and pregnancy-related difficulties. All of those accepted into the MMHS received specialist, individualised care from a qualified Clinical Psychologist or Cognitive Behavioural Therapist, with targeted support and psychoeducation being provided by Assistant Psychologists, where clinically appropriate. This offer demonstrates that the service is operating in line with the recommendations outlined in the NHS Long Term Plan (NHS, 2019a) regarding access goals for mothers.

Importantly, all feedback received by the North Cumbria MMHS has been overwhelmingly positive, with a consensus that the service has delivered an important and beneficial intervention in a timely manner. However, areas for improvement noted by service users noticeably centered on elements outside of the service's immediate control, given current provisions. For example, feedback highlighted the lack of support for fathers and partners who have been impacted by pregnancy and/or childbirth. This is also reflected in the final 2022

Ockenden report, which highlights that services ought to provide timely psychological support to all those impacted by the maternity journey, including partners and families (Department of Health and Social Care, 2022). This is an area that the North Cumbria MMHS team is aware of, and staff do attempt to signpost to appropriate support where possible. However, despite recognising the growing need, the service does not routinely provide care for this group at present, due to limited resources. Findings show that witnessing a partner's birth trauma can have a significant impact on the observer's mental health and relationships in the postnatal period. Yet, no nationally recognized support is in place for fathers (Daniels et al., 2020). As such, we recommend that voluntary and third-sector services be supported and adequately funded to fill this gap. It is also important to recognize the wait experienced by one service user and the effect that this was reported to have, as quoted above. The service aims to see all users in a timely manner; however, at times, factors such as clinician availability or geography may result in some waiting longer than others. Waiting times across the NHS as a whole have increased in recent years, and this, coupled with the previous challenges of operating in North Cumbria, provides further arguments for adequate funding.

Clinical Implications

The North Cumbria MMHS has faced several challenges since its inception. For instance, North Cumbria has a large geographic footprint, which can present a significant barrier to access, as clients may be based at substantial distances from clinical hubs and may be unable to travel independently or rely on public transport. As such, the service has had to operate as flexibly as possible, offering remote therapies, such as CBT and EMDR, via telephone and video conferencing to reduce the "postcode lottery" observed at a national level (APPGBT, 2024).

The size of the service itself has posed an additional challenge, with funding secured only for 1.4WTE members of staff. The number of referrals the North Cumbria MMHS received during the study period was almost triple the anticipated number when the service was established, with the access rate nearly double the target. This indicates that current commissioned funding is insufficient, with staff from the wider PHRP team being asked to contribute their available clinic time to meet demand—an unsustainable option moving forward. Importantly, this has wider implications for whom the service can offer

provision to, given limited resources due to suboptimal staffing numbers, resulting in difficulties offering new patient assessments or longer-term, direct psychological input. This is also compounded by referrals for service users who are quickly approaching their estimated due date and therefore require prioritisation. In practice, this means that those who may have been waiting for input from a qualified practitioner may be further disadvantaged, reinforcing the need for adequate funding to enable the service to meet local needs.

Limitations

The most notable limitation of the present review is the lack of pre- and postintervention outcome measures that were completed and returned by service users. It was initially thought that the low number of outcomes collected may be predominantly due to clinician error. For example, it is not uncommon within the North Cumbria MMHS to complete an extended period of assessment or for service users to have their baby before the work reaches a formal conclusion. As such, this may mean that clinicians could forget to complete the outcome measures at either point or may not have the appropriate opportunity to administer them. There is also a risk of response or self-selection bias in the feedback reported, with those who had positive experiences possibly more likely to respond than those who did not. Furthermore, patient experience data were collected at various points in the patient journey (including during and post-intervention), which may pose a further limitation.

It must also be recognised that, as mentioned above, the sample size of both outcome measures ($n = 12$) is small and, as such, the statistical power and generalizability of this may be limited. In a bid to combat this, strides were taken to make digital distribution the primary method of outcome collection. However, a poor response rate to outcome measures sent via text message or email has been observed. In response, further steps have now been taken to minimise this issue moving forward, including the introduction of reminder messages for those who do not respond. The importance of collecting outcome measures regularly has also been emphasised to clinicians working within the MMHS.

Conclusions

This evaluation shows that the North Cumbria MMHS provided effective mental health care to women across the region who have experienced birth and

pregnancy-related difficulties over the 2023-24 financial year. Significant improvements in psychological distress and overall well-being were observed post-intervention (p = .005), and qualitative patient feedback was overwhelmingly positive, highlighting the qualities of the therapeutic relationship as being key to the work completed and in allowing women to feel more like themselves. Despite covering a large geographic area, the service successfully utilised communication technologies to ensure that appointments were widely available and access was equitable. Further, despite the challenges identified in collecting pre- and postoutcome measures, steps have been taken, and efforts are ongoing to improve data collection for future years.

These efforts include sending reminder messages for digital reporting and building outcome measures into the digital record-keeping process, prompting clinicians to complete the CORE-10 and WEMWBS as part of their note-taking and reporting. Recently, calls for drastic improvements in maternal mental health care at a national level have been made. Based on the current findings, the authors would argue that the North Cumbria MMHS provides a sufficient model for other MMHS services moving forward and demonstrates the importance of offering specialist, timely, and person-centered psychological intervention to women experiencing difficulties in the perinatal period.

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